IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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BUREAU OF FACILITY STANDARDS
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March 3, 2009

Kathy Prophet
Preferred Community Homes - Cougar Creek
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Cougar Creek, Provider #13G037

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Cougar Creek, which was conducted on February 23, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **March 16, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by March 16, 2009. If a request for informal dispute resolution is received after March 16, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2009
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G037 | A. BUILDING _____ B. WING _____ | 02/23/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PREFERRED COMMUNITY HOMES - COUGAR CREEK | 1230 EAST COUGAR CREEK MERIDIAN, ID 83642 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during your annual recertification survey.<br><br>The survey was conducted by:<br>Matt Hauser, QMRP, Team Leader<br>Jim Troutfetter, QMRP<br><br>Common abbreviations/symbols used in this report are:<br>IPP - Individual Program Plan<br>OCD - Obsessive Compulsive Disorder<br>QMRP - Qualified Mental Retardation Professional<br>TID - Three Times per Day | W 000 | Preparation and implementation of this plan of corrections does not constitute admission or agreement by Cougar Creek with the facts, findings, or other statements as alleged by the State agency dated February 23, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Cougar Creek specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action. | |
| W 234 | 483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN<br><br>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 1 of 3 individuals (individual #1) whose behavior support plans were reviewed. This resulted in a lack of sufficient instructions to staff being included in an individual's program. The findings include:<br><br>1. Individual #1's IPP, dated 11/6/08, documented a 30 year old male whose diagnoses included moderate mental retardation, intermittent explosive disorder, obsessive compulsive disorder, and schizoaffective disorder.<br><br>Individual #1's Training Program, dated 11/20/08, included a target behavior of "Hurtful to Self." | W 234 | **W234 483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN**<br><br>Instructions to staff regarding Individual #1's hurtful to self behavior now includes the definition of that behavior. All other individual's behavior plans have been reviewed and all behaviors are defined.<br><br>Person Responsible: QMRP<br>Monitored: monthly<br>Completion date: 3-11-09<br><br>RECEIVED<br><br>MAR 17 2009<br><br>FACILITY STANDARDS | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3-16-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 234 | Continued From page 1<br>Interventions for the behavior included blocking and redirecting of Individual #1 and up to a two person physical restraint.<br><br>However, the plan did not define the behavior. Without a clear definition of the target behavior, it was not clear as to when staff were to intervene.<br><br>When asked during an interview on 2/23/09 from 12:30 - 12:40 p.m., the QMRP stated she was not sure what Individual #1's "Hurtful to Self" behaviors were, but could check past records.<br><br>The facility failed to ensure instructions to staff regarding Individual #1's hurtful to self behavior included a definition of the behavior. | W 234 | | |
| W 312 | 483.450(e)(2) DRUG USAGE<br><br>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behavior for which the drugs were used for 1 of 3 individuals (Individual #1) whose behavior modifying drugs were reviewed. This resulted in an individual receiving a behavior modifying drug without appropriate plans that identified drug usage and how they may change in relation to progress or regression. | W 312 | **W312 483.450(e)(2) DRUG USAGE**<br><br>Individual #1's medication reduction plan has had the typo removed. All Individual's medication reduction plans have been reviewed to ensure there are no additional typo's.<br><br>Person Responsible: QMRP<br>Monitored: monthly<br>Completion date: 3-11-09 | |

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| W 312 | Continued From page 2<br>The findings include:<br><br>1. Individual #1's IPP, dated 11/6/08, documented a 30 year old male whose diagnoses included moderate mental retardation, intermittent explosive disorder, obsessive compulsive disorder, and schizoaffective disorder.<br><br>Individual #1's Physical Examination Report, dated 10/20/08 documented he received Clonazepam 0.5mg. TID (an anticonvulsant drug). His Medication Reduction Plan, revised 1/16/09, documented Clonazepam was prescribed for OCD as characterized by "Hurtful to Self and Hurtful to Others" behavior. However, the criterion section of the Medication Reduction Plan stated destruction of property was an additional behavior to be reduced prior to reducing his Clonazepam.<br><br>When asked during an interview on 2/23/09 from 12:30 - 12:40 p.m., the QMRP stated the destruction of property requirement was a typo.<br><br>The facility failed to ensure Individual #1's medication plan was adequately developed. | W 312 | | |
| W 322 | 483.460(a)(3) PHYSICIAN SERVICES<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided to 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in | W 322 | **W322 483.460 (a)(3) PHYSICIAN SERVICES**<br><br>All Individual's RSO's will and have been individualized and we are working on obtaining physician's signatures. As for the Tylenol and Ibuprofen issue – "Per Nursing Judgment" will be on all the RSO's and we will also make sure that if anyone cannot tolerate either medication, it is noted on their orders. | |

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| W 322 | Continued From page 3<br>unclear information regarding which as needed medications individuals should receive. The findings include:<br><br>1. Individual #1 - #3's routine standing orders included the following:<br><br>- Tylenol (a nonopioid analgesic drug) to be given every 4 hours as needed for pain or fever.<br>- Ibuprofen (a nonsteroidal anti-inflammatory drug) to be given every 4 to 6 hours as needed for fever or pain.<br><br>It was not clear which drug (Tylenol or Ibuprofen) was to be given if the individuals had a fever or were in pain.<br><br>Individual #1 - #3's routine standing orders also included the following:<br><br>- Milk of Magnesia (a laxative drug) to be given as needed for constipation.<br>- Bisacodyl suppository (a laxative drug) to be given as needed for constipation.<br><br>It was not clear which drug, the Milk of Magnesia or a Bisacodyl suppository, was to be given to the individuals for constipation.<br><br>When asked, during an interview on 2/24/09, at 11:02 a.m., the facility's registered nurse stated she understood that individual's routine standing orders should be updated and clarified.<br><br>2. Individual #3's 1/22/09 IPP stated he was a 42 year old male whose diagnoses included mild mental retardation and Type I Diabetes.<br><br>His Physician's Orders, dated 12/08, stated he | W 322 | Person Responsible: House Nurse<br>Monitored: monthly<br>Completion date: 3-11-09 (with the exception of those still waiting on Dr.'s signatures) | |

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| W 322 | Continued From page 4<br>was to receive baking soda dissolved in warm water, 3-4 drops into each ear twice daily for 7 days as needed for ear wax removal. However, his routine standing orders, dated 2/29/08, stated he was to receive Debrox as needed for cerumen (ear wax) build up.<br><br>It was not clear which treatment Individual #3 was to receive for ear wax build up.<br><br>Additionally, Individual #3's routine standing orders, stated he was to receive Ensure (a dietary supplement) as needed for meal refusals. However, his IPP stated he was to be on a low concentrated sweets, American Diabetes Association diet, with restricted fluids, and "offer only skim milk, water, and diet drinks, offer low calorie and high protein snacks..."<br><br>When asked, during an interview on 2/24/09, at 11:05 a.m., the facility's registered nurse stated Individual #3 should not get Ensure for meal refusals due to his diabetes.<br><br>The facility failed to ensure follow up with the physician occurred in order to clarify which as needed drugs and supplements Individuals #1 - #3 should be receiving. | W 322 | | |
| W 388 | 483.460(m)(1)(i) DRUG LABELING<br><br>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, it was determined the facility failed to ensure all medications were correctly labeled for | W 388 | | |

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| W 388 | Continued From page 5<br>1 of 3 individuals, (individual #3) whose records were reviewed. This resulted in the potential for medication administration errors and subsequent negative impacts to the individual. Findings include:<br><br>1. Individual #3's 1/22/09 IPP stated he was a 42 year old male whose diagnoses included mild mental retardation and Type I Diabetes.<br><br>His Physician's Orders, dated 12/08, stated he was to receive a laxative medication, sugarfree Citrucel Powder (a laxative drug), 15 cc in 8 ounces of water twice daily, at 8 a.m. and 8 p.m. Additionally, Individual #3's 1/09 Medication Administration Record documented he received Citrucel Powder twice daily at 8 a.m. and 8 p.m.<br><br>During and environmental review on 2/19/09 from 10:05 - 11:08 a.m., a Citrucel Powder container was noted to not have a pharmacy label and did not include the dosage or times individual #3 was to receive the medication.<br><br>When asked about Citrucel Powder not having a pharmacy label, the facility Registered Nurse stated, on 2/24/09 at 10:59 a.m., that she understood the need for pharmacy labels for drugs ordered by a physician and used daily by individuals.<br><br>The facility failed to ensure all drugs were labeled according to professional practice. | W 388 | **W388 483.460(m)(1) DRUG LABELING**<br><br>All individual's medications are labeled. We will ensure all OTC medications that are prescribed for use on a daily basis come from the pharmacy and are labeled for the individual.<br>Person Responsible: House Nurse<br>Monitored: monthly<br>Completion date: 3-11-09 | |

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| MM197 | 16.03.11.075.10(d) Written Plans<br><br>Is described in written plans that are kept on file in the facility; and<br><br>This Rule is not met as evidenced by:<br>Refer to W312. | MM197 | MM197 16.03.11.075.10(d) Written Plans<br><br>Refer to W312 | |
| MM271 | 16.03.11.100.04(b) Storage of Toxic Chemicals<br><br>All toxic chemicals must be properly labeled and stored under lock and key.<br>This Rule is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 5 of 5 individuals (individuals #1 - #5) residing in the facility. The findings include:<br><br>An environmental review was conducted on 2/19/09 from 10:05 - 11:08 a.m. At that time, the following toxic chemicals (all with hazardous chemical label warnings) were noted to be unlocked on a shelf in the garage:<br><br>- Two cans of Carpet Cleaner.<br>- No less than 3 containers of RainX de-icer.<br>- Two large bottles of Magic Foam Carpet Cleaner.<br>- One spray bottle of Liquid Vinyl.<br>- One can of paint.<br><br>The Home Manager of the facility was present during the environmental review, and stated that the chemicals had always been stored in the garage. The Home Manager immediately placed the above items in a locked storage area on 2/19/09.<br><br>Two plastic cans of gasoline were also in the | MM271 | MM271 16.03.11.100.04(b) Storage of Toxic Chemicals<br><br>All toxic chemicals are labeled and stored under lock and key.<br><br>Person Responsible: House RSC<br>Monitored: daily<br>Completion date: 3-11-09<br><br>RECEIVED<br>MAR 17 2009<br>FACILITY STANDARDS | |

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| MM271 | Continued From page 1<br>garage on a trailer with two lawn mowers.<br><br>These were removed from the facility by the Home Manager immediately.<br><br>The facility failed to ensure all toxic chemicals were stored in a locked storage area. | MM271 | MM380 16.03.11.120.03(a) Building and Equipment<br><br>Food debris on the microwave turntable have been removed<br>The hinge pins on the door of the hall linen closet have been repaired.<br>Individual #5's vent has been cleaned.<br>Completed by 3-11-09 | |
| MM380 | 16.03.11.120.03(a) Building and Equipment<br><br>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.<br>This Rule is not met as evidenced by:<br>Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. The findings include:<br><br>An environmental survey was conducted on 2/19/09 from 10:05 - 11:08 a.m. The following concerns were noted:<br><br>Kitchen:<br>- There was food debris on the microwave turntable.<br><br>Hall:<br>- The hinge pins on the door of the hall linen closet were protruding approximately 2 inches from each of the hinges.<br><br>Bathroom: | MM380 | | |

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| MM380 | Continued From page 2<br>- Individual #5's bathroom vent was covered in dust. | MM380 | | |
| MM428 | 16.03.11.120.10(c) Tempeature of hot water<br><br>The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit.<br>This Rule is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 5 of 5 individuals, (Individuals #1 - #5) residing at the facility.<br>Findings include:<br><br>An environmental survey was conducted at the facility on 2/19/09 from 10:05 - 11:08 a.m., and showed the following hot water temperatures (Fahrenheit):<br><br>Medication bathroom sink - hot water temperature was 123.9 degrees.<br><br>Bathroom sink used by Individuals #3 and #5 - hot water varied in temperatures, which ranged from 80 - 105 degrees in a 5 minutes period.<br><br>Additionally a follow up check of the water temperatures conducted on 2/20/09 from 9:02 - 9:24 a.m. documented the following water temperatures:<br><br>Kitchen sink - hot water varied in temperatures, which ranged between 60 - 116 degrees in a five minute period. At this time the staff present was informed of the fluctuation in water temperature and advised to not have individuals bathe or shower until the water heater was fixed. The staff | MM428 | MM428 16.03.11.120.10(c)<br>Temperature of hot water<br><br>A professional company was called and the water heaters were repaired.<br><br>Person Responsible: House RSC and Administrator<br>Monitored: daily<br>Completion date: 3-11-09 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| MM428 | Continued From page 3<br>present stated the there would be someone coming out later in the day to fix the water heater.<br><br>The facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit. | MM428 | | |
| MM696 | 16.03.11.250.09(d)(i) Refrigerator and Freezer<br><br>Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below.<br>This Rule is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure each freezer was equipped with a reliable, easily read thermometer for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. The findings include:<br><br>An environmental review, conducted at the facility on 2/19/09 from 10:05 - 11:08 a.m., showed there was no thermometer in the freezer by the kitchen entrance. The freezer contained various food items including bacon. The Home Manager who was present during the environmental review was informed of the missing thermometer and stated she would have it replaced. | MM696 | MM696 16.03.11.250.09(d)(i) Refrigerator and Freezer<br><br>A thermometer is now in place in the freezer by the kitchen entrance.<br><br>Completion date: 3-11-09 | |
| MM735 | 16.03.11.270.02 Health Services<br><br>The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and | MM735 | MM735 16.03.11.270.02 Health Services<br><br>Refer to W322 | |

PRINTED: 02/27/2009
FORM APPROVED

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G037 | A. BUILDING _____ B. WING _____ | 02/23/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| MM735 | Continued From page 4<br>planned health services, medications and diets are made available to each resident as ordered must be provided as follows:<br>This Rule is not met as evidenced by:<br>Refer to W322. | MM735 | | |
| MM855 | 16.03.11.270.08(c) Training and Habilitation Record<br><br>There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident.<br>This Rule is not met as evidenced by:<br>Refer to W234. | MM855 | MM855 16.03.11.270.08(c) Training and Habilitation<br><br>Refer to W234 | |